Children's Clinic of Pascagoula, PLLC

Release of Information

- **Hurley Office PO BOX 938 Hurley, MS 39555 Phone: 228.588.6166 Fax: 228.588.6253**
- **Pascagoula Office 4105 Hospital Rd Suite 103 Pascagoula, MS 39562 Phone: 228.762.8712 Fax: 228.762.2261**
- **Lucedale Office Can be sent to the Pascagoula Address Phone: 601.514.1073 Fax: 601.514.1076**

Please check one of the following options:

- I hereby authorize Children's Clinic of Pascagoula, PLLC to ***release*** the following information from the medical record(s) of:
- I hereby authorize Children's Clinic of Pascagoula, PLLC to ***request*** the following information from the medical record(s) of:

Name:_____Date of Birth:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip_____

Information to be released: ***ALL*** or ***Specific Dates***_____

_____Notes from office visit
_____Immunizations
_____Other-Please List

Records are to be:
Please check one of the following options:

- Requested from
- Sent to

Name or Company:_____

Address:_____

City_____ State_____ Zip Code_____

Phone_____ Fax_____

Purpose of Disclosure:

___Attorney/Legal

___Continued Patient care

___Personal Use

___Commercial Use

___ Other (Specify)

I understand that such medical records may contain information regarding psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted disease or complications related to sexually transmitted diseases, including but not limited to HIV testing and results. I hereby authorize the release of such medical records pursuant to the authorization for release or request of medical records, and waiver confidentiality provisions pertaining to this release. I understand letters correspondences and copies of medical records from other healthcare provider will not be released.

Specification of the date, event, or condition upon which the consent expires (i) after 3 months (ii)after disclosure is made (iii)the date specified here_____

The employees and physicians are hereby released from any legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that any disclosure of information carries with it the potential for redisclosure and information that be be protected by federal confidentiality rules. I understand that I have the right to revoke this authorization at any time. I understand that my revocation will not apply to information already released based on this authorization.

Signature_____ Date_____

If Legal Representative, State Relationship_____

Patient Unable to Sign_____Reason_____

Witnessed_____ Date_____